MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

Reset

FR01

DO NOT USE THIS SPACE

1. **EMPLOYEE SOCIAL SECURITY #**	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm

4. **DATE OF CLAIMED INJURY**	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)

7. **EMPLOYEE** Name (last, suffix, first, middle)	8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried

10. Home address	11. Home phone #	12. Date of birth	13. Date hired
City State Zip Code	14. Occupation	15. Regular department	16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. First date of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No 32. RTW with restrictions ☐ Yes ☐ No

33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated
35. Certified Managed Care Organization (if any)	

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)
PARAKLATOS INC. DBA	PKT ENTERPRISES
38. **Mailing** address	39. Employer FEIN / 40. Unemployment ID #
724 NORTH 1ST STREET, SUITE 600	411790674
City State Zip Code	41. Employer's contact name and phone #
MINNEAPOLIS MN 55401	PAT MATT 612/788-3998 EXT. 104
42. **Physical** address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet
City State Zip Code	44. NAICS code / 45. Date form completed

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☑ Insurer ☐ TPA
SFM MUTUAL INSURANCE	SFM MUTUAL INSURANCE COMPANY
47. Insured legal name and FEIN	52. CA address
PARAKLATOS INC. 411790674	CLAIMS SERVICES, PO BOX 9416
48. Policy # (including effective dates) or self-insured certificate #	City State Zip Code
SF.358692.206	MINNEAPOLIS MN 55440
49. Insurer FEIN / 50. Date insurer received notice	53. CA FEIN / 54. CA claim #
411459789	411459789

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see www.usa.gov/Business/Business-Gateway.shtml and click on "Get an Employer ID Number".
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date of injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (see Minn. Stat. § 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

- Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
- Items 47-48: Fill in the legal name and Federal Employer Identification Number (FEIN) of the employer who purchased the policy from the insurer (named in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
- Item 49: Fill in the insurer's FEIN.
- Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
- Item 53-54: Fill in the claims administrator's FEIN and claim number.
- Item 55: These items apply only to FROIs electronically submitted by the claim administrator.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.